

**TRANSMITTAL AND NOTICE OF APPROVAL OF  
STATE PLAN MATERIAL**  
FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER:

0 1 — 0 3

2. STATE:

WV

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

4. PROPOSED EFFECTIVE DATE

May 1, 2001

TO: REGIONAL ADMINISTRATOR  
HEALTH CARE FINANCING ADMINISTRATION  
DEPARTMENT OF HEALTH AND HUMAN SERVICES

5. TYPE OF PLAN MATERIAL (Check One):

☒ NEW STATE PLAN

☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN

☐ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT (Separate Transmittal for each amendment)

6. FEDERAL STATUTE/REGULATION CITATION:

SSA 1902(e)(12)

7. FEDERAL BUDGET IMPACT:

a. FFY 2001 \$ 6 million

b. FFY 2002 \$ 21 million

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:

Attachment 2.2-A  
Page 23c

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (If Applicable):

10. SUBJECT OF AMENDMENT:

Continuous eligibility for 12 months for children up to the age of 19 years

11. GOVERNOR'S REVIEW (Check One):

☐ GOVERNOR'S OFFICE REPORTED NO COMMENT

☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED

☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL

☐ OTHER, AS SPECIFIED:

12. SIGNATURE OF STATE AGENCY OFFICIAL:

*Phillip A. Lynch*

13. TYPED NAME:

Phillip A. Lynch

14. TITLE:

Acting Commissioner

15. DATE SUBMITTED:

16. RETURN TO:

Phillip A. Lynch, Acting Commissioner  
Bureau for Medical Services  
350 Capitol Street, Room 251  
Charleston, WV 25301-3706

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED

5/2/01

18. DATE APPROVED

June 13, 2001

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:

5/1/01

20. SIGNATURE OF REGIONAL OFFICIAL:

*V. Campbell for CVC*

21. TYPED NAME:

CLAUDETTE V CAMPBELL

22. TITLE:

~~DIVISION~~ ASSOCIATE REGIONAL ADMIN  
DIVISION OF MEDICAID  
& STATE OPERATIONS

23. REMARKS:

40-1001 411

Citation

Groups Covered

B. Optional Coverage Other Than The Medically Needy  
(Continued)1902 (a) (10) (A)(ii) (XIV)  
of the Act

- \_\_\_\_\_ 19. Optional Targeted Low Income Children who:
- a. are not eligible for Medicaid under any other optional or mandatory eligibility group or eligible as medically needy (without spenddown liability);
  - b. would not be eligible for Medicaid under the policies in the State's Medicaid plan as in effect on March 31, 1997 (other than because of the age expansion provided for in §1902 (1) (2) (D) );
  - c. are not covered under a group health plan or other group health insurance (as such terms are defined in §2791 of the Public Health Service Act coverage) other than under a health insurance program in operation before July 1, 1997 offered by a State which receives no Federal funds for the program;
  - d. have family income at or below:  
  
200 percent of the Federal poverty level for the size family involved, as revised annually in the Federal Register; or  
  
A percentage of the Federal poverty level, which is in excess of the "Medicaid applicable income level" (as defined in §2110 (b) (4) of the Act) but by no more than 50 percentage points.

The State covers:

- \_\_\_\_\_ All children described above who are under age nineteen (19) with family income at or below \_\_\_\_\_ percent of the Federal poverty level.
- \_\_\_\_\_ The following reasonable classifications of children described above who are under age nineteen (19) with family income at or below the percent of the Federal poverty level specified for the classification.

1902 (e) (12) of the Act

- X 20. A child under age nineteen (not to exceed age 19) who has been determined eligible is deemed to be eligible for a total of twelve months (not to exceed 12 months) regardless of changes in circumstances other than attainment of the maximum age stated above.

TN No. 01-03  
Supersedes  
TN No. NEWApproval Date JUN 13 2001 Effective Date 5/1/01